Shannon DeShazo, **M.D. PATIENT MEDICAL HISTORY FORM** *THIS INFORMATION BECOMES PART OF YOUR CONFIDENTIAL MEDICAL RECORDS*

NAME: FIRST MIDDLE LAST

AGE_____ TODAY'S DATE_____

MARTIAL STATUS_____RELIGION_____

TYPE OF WORK EMPLOYED NOW
Self_____ Yes No
Spouse_____ Yes No

EDUCATION (Years Completed)
Grade_____High_____Vocational_____College_____

PREVIOUS PHYSICIAN_____

PAST MEDICAL HISTORY (Description and Dates)

PREVIOUS SURGERY OR HOSPITALIZAITONS	
MAJOR ILLNESSES OR INJURIES	
PLEASE CIRCLE IF PRESENT	DIABETES HIGH BLOOD PRESSURE STROKE HEART ATTACK SERIOUS ACCIDENT CANCER TUBERCULOSIS EMPHYSEMA

FAMILY HISTORIES	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS NUMBER_____			
SISTERS NUMBER_____			
CHILDREN NUMBER_____			

NUMBER OF PERSONS LIVING IN YOUR HOUSEHOLD_____

SPEICIFY WHICH RELATIVE HAS HAD THE FOLLOWING

DIABETES……
HEART TROUBLE……
HIGH BLOOD PRESSURE……..
STROKE……
CANCER……
THYROID TROUBLE……..
HIGH CHOLESTEROL……
BREAST CANCER……..
ARTHRITIS……..
ALZHEIMERS……
SUICIDE……..
MENTAL ILLNESS……

PLEASE COMPLETE IF ANY APPLY

SMOKING:
PACKS/DAY____AGE STARTED____
YEAR STOPPED_____
PIPE____CIGAR_____CHEW_____

ALCOHOL:
DRINKS/DAY_____WEEK_____ /MONTH_____
ALCOHOL PROBLEM: YES___NO___

COFFEE:
CUPS/DAY_____
ASPIRIN:
TABS/DAY_____

PRESENT HEIGHT_____ PRESENT WEIGHT_____ WEIGHT AT AGE 20_____ WEIGHT CHANGE LAST YEAR: GAINED_____LBS LOST_____LBS

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING
(EXAMPLES-HEART MEDICATIONS, CHOLESTEROL MEDICATIONS, BLOOD PRESSURE MEDICATIONS, PAIN MEDICATIONS, BIRTH CONTROL, VITAMINS, THYROID MEDICATIONS, HERBS, OVER THE COUNTER MEDICATIONS, DIET MEDICATIONS.)

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PLEASE SPECIFY ANY ALLERGIES YOU HAVE TO MEDICINES:_____

OVER-COMPLETE PAGE 2-OVER

PLEASE CHECK ANY CURRENT OR RECENT (Within 90 days) SYMPTOMS OR COMPLAINTS AND/OR WRITE IN ANY OTHER SYMPTOMS OR COMPLAINTS

GENERAL HEALTH	[ ] FATIGUE	[ ] WEAKNESS	[ ] WEIGHT PROBLEMS	
HEENT	[ ] HEADACHE	[ ] HEARING PROBLEM	[ ] EAR RINGING	[ ] SINUS PROBLEMS
	[ ] HOARSENESS	[ ] EYE PROBLEM		
RESPIRATORY	[ ] COUGH	[ ] COUGH UP BLOOD	[ ] SHORTNESS OF BREATH	
	[ ] WHEEZING	[ ] PLEURISY		
CARDIAC	[ ] CHEST PAIN OR TIGHTNESS	[ ] HEART MURMUR	[ ] PALPATATIONS	
	[ ] LEG PAIN WITH WALKING	[ ] ANKLE SWELLING		
GASTROINTESTINAL	[ ] SWALLOWING TROUBLE	[ ] INDIGESTION	[ ] ULCERS	[ ] VOMITTING BLOOD
	[ ] BLACK OR BLOODY STOOLS	[ ] ABDOMINAL PAIN	[ ] DIARRHEA	[ ] CONSTIPATION
	[ ] JAUNDICE	[ ] CHANGE IN BOWEL MOVEMENTS		[ ] HEMMORHOIDS
NEURO-PSYCH PROBLEMS	[ ] TENSE	[ ] IRRITABLE	[ ] DEPRESSED	[ ] INSOMNIA [ ] MARITAL OR JOB
	[ ] FAINTING	[ ] DIZZINESS	[ ] SEIZURES	[ ] SEXUAL DIFFICULTY
MUSCULOSKELETAL	[ ] ARTHRITIS OR JOINT PAIN	[ ] GOUT	[ ] BACK PAIN	[ ] BUSITIS [ ] TENDONITIS
GENITOURINARY	[ ] BLADDER OR KIDNEY INFECTIONS OR PROBLEMS		[ ] KIDNEY STONES	[ ] SLOW URINATION
	[ ] DIFFICULTY OR PAINFUL URINATION	[ ] BLOOD OR PROTEIN IN URINE		[ ] PROSTATE PROBLEM
OTHER	[ ] SKIN PROBLEMS	[ ] ALLERGIES	[ ] ANEMIA	[ ] BLOOD DISEASE

GYN **FOR WOMEN ONLY** (PLEASE FILL OUT CAREFULLY)

AGE MENSTRUATION STARTED_____	PERIOD EVERY _____ DAYS	FLOW LASTS _____DAYS	LAST MENSTRUAL DATE_____	DATE OF LAST PAP SMEAR_____

MENSTRAUL PROBLEMS [ ] HEAVY PERIOD [ ] IRREGULAR [ ] PAINFUL [ ] INFREQUENT [ ] SPOTTING [ ] VAGINAL DISCHARGE
[ ] HOT FLASHES [ ] INFERTILITY [ ] SEXUAL DIFFICULTY [ ] BREAST LUMP [ ] BREAST DISCHARGE

NUMBER OF PREGNANCIES_____	NUMBER OF MISCARRIAGES_____	PLEASE LIST ANY BIRTH CONTROL METHODS USED _____

_____ _____

PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**